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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 156

[CMS-9917-F]

RIN 0938-AT93

Patient Protection and Affordable Care Act; Elimination of Internal Agency Process for Implementation of the Federally-facilitated User Fee Adjustment

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: The U.S. Department of Health and Human Services (HHS) is issuing this final rule to eliminate references to internal Executive Branch procedures provided for under Office of Management and Budget (OMB) circular A-25R in connection with an adjustment to the Federally-facilitated Exchange (FFE) user fee. HHS is amending these regulations because it has determined that an exception to OMB circular A-25R is not required to effectuate the FFE user fee adjustment. Thus, this final rule removes the language that refers to an exception under OMB circular A-25R as an aspect of reducing a participating issuer's FFE user fee obligation. This rule does not affect the ability of an issuer to obtain an applicable reduction in FFE user fee obligations, amend the calculation of the FFE user fee credit provided to a participating issuer, change the application of the monthly user fee adjustment, or alter any of the other standards that participating issuers must meet to qualify for the user fee adjustment.

DATES: These regulations are effective on [Insert date 30 days from date of publication in the Federal Register].

FOR FURTHER INFORMATION CONTACT:

Jaya Ghildiyal, (301) 492-5149, or Adrienne Patterson, (410) 786-0686.

SUPPLEMENTARY INFORMATION:

I. Background

A. Determination to Issue a Final Rule

The U.S. Department of Health and Human Services (HHS) is publishing this final rule without previously publishing a proposed rule because HHS has determined that the rule qualifies for exemption from notice-and-comment rulemaking under section 553 of the Administrative Procedures Act (Pub. L. 79-404, enacted June 11, 1946) (APA), both because it is a “matter relating to agency management” under section 553(a)(2)¹ and a “rule of agency organization, procedure or practice” under section 553(b)(3)(A). This rule eliminates an unnecessary reference to an internal inter-agency process, but makes no changes to the policy or operational processes set forth for participating FFE issuers or third parties subject to 45 CFR 156.50(d), and will have no effect on these entities or the other individuals and entities that were subjects of the July 2, 2013 final rule “Coverage of Certain Preventive Services Under the Affordable Care Act” (78 FR 39870), namely eligible organizations, self-insured plans of eligible organizations, and participants and beneficiaries of those plans.

B. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted March 23, 2010) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted

¹ Although HHS’s predecessor agency, the U.S. Department of Health, Education, and Welfare (HEW), waived the APA’s exemption to the requirement for notice and comment rulemaking for “public property, loans, grants, benefits, or contracts” in section 553(a)(2), see “Public Participation in Rule Making,” 36 FR 2532 (Feb. 5, 1971), HEW did not waive the exemption in section 553(a)(2) for “matter[s] relating to agency management or personnel.”

March 30, 2010) are collectively referred to as “PPACA” in this final rule. Section 1321(a) of the PPACA provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, qualified health plans (QHPs), and other components of title I of the PPACA. When operating an FFE under section 1321(c)(1) of the PPACA, HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the PPACA to collect and spend user fees. OMB Circular A-25 Revised (OMB Circular A-25R) establishes federal policy regarding user fees and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from federal activities beyond those received by the general public.

Section 2713(a)(4) of the Public Health Service Act, as added by the PPACA and incorporated into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code, requires that non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage provide certain women’s preventive health services as a benefit without cost sharing, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. On July 2, 2013, the final rule “Coverage of Certain Preventive Services Under the Affordable Care Act” (78 FR 39870) published by HHS, the Department of the Treasury, and the Department of Labor, set forth regulations allowing eligible organizations to receive an accommodation relating to coverage of contraceptive services, so that they are not required to provide, arrange, or pay for these services. Those regulations at 45 CFR 147.131, 26 CFR 54.9815-2713A, and 29 CFR 2590.715-2713A were amended, but largely left in place, by interim final rules with requests for comments published in the **Federal Register** on October 13, 2017, Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act

(82 FR 47792) and Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (82 FR 47838) and final rules published in the **Federal Register** on November 15, 2018, with an effective date of January 14, 2019, Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (83 FR 57536) and Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (83 FR 57592). The 2013 final regulation also set forth processes and standards at §156.50(c) and (d) to take into account the payments for the contraceptive services that are provided for participants and beneficiaries in self-insured plans of eligible organizations under the accommodation described in that final rule through an adjustment in the FFE user fee payable by an issuer participating in an FFE, at no cost to plan participants or beneficiaries, eligible organizations, third party administrators, or issuers.

II. Provisions of the Final Regulations

This final rule amends the regulations for adjustments of FFE user fees set forth at §156.50, as established in the final rule published in the July 2, 2013 **Federal Register**. HHS is amending §156.50(d)(3), to remove the current language providing that an authorizing exception under OMB Circular No. A-25R must be in effect in order for HHS to provide a participating issuer a reduction in its obligation to pay the FFE user fee. HHS will calculate the user fee reduction as the sum of the total dollar amount of the payments for contraceptive services submitted by applicable third party administrators, as described in paragraph (d)(2)(iii)(D), and an allowance, specified by HHS, for administrative costs and margin.

HHS is also amending §156.50(d)(4) to remove a corresponding requirement that an authorizing exception under OMB Circular No. A-25R be in effect. If the amount of the

reduction under §156.50(d)(3) is greater than the amount of the obligation to pay the FFE user fee in a particular month, the participating issuer will be provided a credit in succeeding months in the amount of the excess.

HHS has determined that an exception to OMB Circular No. A-25R is not required to be in effect to effectuate the FFE user fee adjustment for participating issuers. HHS has implemented an adjustment to FFE user fee collections for each benefit year beginning with the 2014 benefit year, and the adjustment has accounted for less than 2 percent of total FFE user fee collections for each benefit year. Therefore, HHS continues to believe that the adjustment to FFE user fee collections will not materially undermine FFE operations. HHS believes that the reduced user fee collections resulting from the adjustment will not necessitate an exception to OMB Circular No. A-25R. Subject to HHS's standing financial management procedures, HHS will continue to monitor user fee collections and expenditures to ensure compliance under OMB Circular No. A-25R going forward. Additionally, HHS notes that it has not raised the FFE user fee finalized in the annual notice of benefit and payment parameters to offset the FFE user fee adjustments for any applicable benefit year. HHS estimates that payments for contraceptive services will continue to represent only a small portion of total FFE user fees in future benefit years, and it does not anticipate that it will need to increase the FFE user fee rate to offset the FFE user fee adjustment available to participating issuers.

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, et seq.).

IV. Regulatory Impact Analysis

HHS has examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (Pub. L. 96-354, enacted September 19, 1980) (RFA), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4, enacted March 22, 1995), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs. Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for major rules with economically significant effects (\$100 million or more in any one year).

This final rule is not “economically significant” within the meaning of section 3(f)(1) of Executive Order 12866 because it is unlikely to have an annual effect of \$100 million in any single year. In addition, for the reasons noted in this final rule, HHS does not believe that this final rule is a major rule under the Congressional Review Act.

The RFA requires agencies to analyze options for regulatory relief of small businesses. This rule would not have a significant impact on small businesses.

In addition, section 1102(b) of the Act requires HHS to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This rule would not have a significant impact on small rural hospitals because the amendments contained in this final rule do not pertain to hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by state, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately \$150 million. HHS anticipates this rule would not impact state governments or the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. HHS does not anticipate this rule would impose direct requirement costs on state or local governments, preempt state law, or otherwise have federalism implications.

List of Subjects in 45 CFR Part 156

Administrative appeals, Administrative practice and procedure, Advertising, Advisory Committees, American Indian/Alaska Natives, Brokers, Conflict of interest, Consumer protection, Cost-sharing reductions, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Payment and collections reports, Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Taxes, Technical assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR part 156 as set forth below:

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

1. The authority citation for part 156 is revised to read as follows:

Authority: 42 U.S.C. 18021-18024, 18031-18032, 18041-18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701.

2. Section 156.50 is amended by revising paragraphs (d)(3) and (4) to read as follows:

§156.50 Financial support.

* * * * *

(d) * * * * *

(3) If the requirements set forth in paragraph (d)(2) of this section are met, the participating issuer will be provided a reduction in its obligation to pay the Federally-facilitated Exchange user fee specified in paragraph (c) of this section equal in value to the sum of the following:

(i) The total dollar amount of the payments for contraceptive services submitted by the applicable third-party administrators, as described in paragraph (d)(2)(iii)(D) of this section; and

(ii) An allowance for administrative costs and margin. The allowance will be no less than 10 percent of the total dollar amount of the payments for contraceptive services specified in paragraph (d)(3)(i) of this section. HHS will specify the allowance for a particular calendar year in the annual HHS notice of benefit and payment parameters.

(4) If the amount of the adjustment under paragraph (d)(3) of this section is greater than the amount of the participating issuer's obligation to pay the Federally-facilitated Exchange user

fee in a particular month, the participating issuer will be provided a credit in succeeding months in the amount of the excess.

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Dated: November 16, 2018.

Seema Verma,
Administrator,
Centers for Medicare & Medicaid Services.

Dated: November 20, 2018.

Alex M. Azar II,
Secretary,
Department of Health and Human Services.